The Australian Medical Association (WA) is Western Australia's peak medical representative body, and the only independent organisation acting on behalf of Western Australian doctors. We represent the views of WA's medical profession to the government and community and seek the resolution of major social and community health issues from a moral, ethical and medical perspective representing the interests of patients and the people at the core of our engagement.

In the spirit of reconciliation, the AMA (WA) acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

1 Principles that should guide reform

1.1 The AMA (WA) supports removing offences relating to abortion services from criminal legislation. Abortion is a health issue, not a criminal issue.

1.2 There should be equity of access across WA to appropriate abortion services under the leadership of a doctor.

1.3 The WA Government should ensure access to safe and legal termination services, based on need and not limited by age, socioeconomic determinants, culture, location, intersex status and gender identity.

1.4 The AMA (WA) recognises that not all patients seeking an abortion identify as female. We use the term patient.

1.5 The AMA (WA) notes that the Discussion Paper deals with a select number of themes relevant to abortion service reform. A number of the presented reform options depart significantly from the context detailed in the Discussion Paper, including the role that health practitioners[1] may play in providing access to abortion services. Reform in these areas requires far greater and more detailed consideration and expert engagement, with clearly outlined evidence-based reasoning behind proposed changes.

1.6 Reform and development of draft legislation should be guided by further consultation and engagement with medical groups including the AMA (WA), relevant medical and professional colleges and medical practitioners currently involved in the delivery of abortion services in Western Australia.

1.7 The WA Government should seek input on draft legislation prior to its introduction to WA Parliament, to ensure access to abortion services and safety and quality of abortion service delivery in WA.

1.8 Data collection and reporting on abortion services is important to public health and infrastructure planning. It is essential that data continues to be collected to inform healthcare services in WA and support assessment of health care strategies.

1.9 Trainee specialist and specialist medical workforce shortages in WA affect patients' access to care, including access to abortion services. Medical workforce planning, including providing training in surgical abortion techniques, is required to ensure WA health services are able to provide services.

1.10 The AMA (WA) refers to the Australian Medical Association's position statements:
1.10.1 Sexual and Reproductive Health (2014)

[1] An individual who qualified in the practice of a particular field of the health profession and registered with the relevant regulatory authority, not limited to medical practitioner.

1.10.2 Women's Health (2014)
1.10.3 Code of Ethics (2016)
1.10.4 Ethical Issues in Reproductive Medicine (2019)
1.10.5 Conscientious Objection (2019)

2 Regulatory options in relation to informed consent and mandatory counselling requirements

2.1 The AMA (WA) supports removing existing legislated provisions that require mandatory counselling in order to obtain informed consent.

2.2 In some instances, patients will greatly benefit from further specialist medical and health practitioner advice, support and counselling. Medical practitioners can refer and support patients in line with existing standards of care and professional obligations, if required.

2.3 The WA Government has an obligation to ensure such services are accessible to all and reform should not diminish access to such services, to support informed decision making.

3 Requirement for two medical practitioners to be involved before a woman (sic) can have an abortion

3.1 The AMA (WA) supports amending provisions to allow only one ***medical practitioner*** to be involved, excluding late abortions (see Section 5, where additional specialist medical approval is required).

3.2 The AMA (WA) is concerned by the use of the term 'health practitioner' in the Discussion Paper in relation to proposed regulatory options regarding the current requirement for two medical practitioners to be involved before a patient can have an abortion.

3.3 The Discussion Paper does not outline an evidence basis, justification or preceding consideration regarding the expansion of regulatory options to include other AHPRA registered health practitioners.

3.4 The AMA (WA) understands that some respondents have supported Option 2 without realising the significance of the use of the term 'health practitioner'. Therefore, the AMA (WA) is of the view that respondent support for Option 2 should not be considered as synonymous with support for expanding criteria to include AHPRA registered health practitioners other than medical practitioners.

3.5 The AMA (WA) reserves any comment on which health practitioners could be involved before a patient can have an abortion. Such reform should only occur following greater consideration of expansion of involvement to other appropriately trained and qualified health practitioners, including considered justification, training and supervision requirements and meaningful consultation with stakeholders (including relevant medical colleges) on that issue.

3.6 Central to the AMA (WA)'s view on the proposed regulatory options is patient safety, established care pathways, required medical expertise and support, and the importance of ensuring auditable data capture.

3.7 Providing abortion services requires medical practitioners to ensure the patient has the tools and counselling services to minimise a further unplanned pregnancy and provide appropriate post-abortion contraception and health care. In some instances, this will include providing support to address social concerns, including domestic violence and sexually transmitted diseases. Medical practitioners' training and experience are central to providing this service safely.

4 Regulatory options in relation to conscientious objection

4.1 Doctors who have conscientious objections should not be expected to participate in clinical or research activities to which they have an objection. The AMA (WA) supports the right to allow health practitioners to conscientiously object to requests for abortion services.

4.2 Doctors hold differing views regarding abortion. The Australian Medical Association Position Statement *Ethical Issues in Reproductive Medicine (2019)* states that where a doctor has a conscientious objection to abortion, they should inform the patient of their objection and ensure the impact of a delay in treatment does not constitute a significant impediment to the patient accessing services.

4.3 The Australian Medical Association *Code of Ethics (2004, Revised 2006;2016*) states that doctors should not use conscientious objection to impede patients' access to medical treatments including in an emergency situation.

4.4 The AMA (WA) strongly believes that conscientious objection should not impede access to medical care and reform must protect patients access to abortion services.

4.5 Requiring a conscientious objector to refer to a medical practitioner that does provide abortion services is unnecessary as a referral, as defined under the *Health Insurance Act 1973 (Cth)*, relates to an escalation from primary to specialist care. Accessing a primary care service does not require a referral. Abortion (especially in the first trimester) is usually a primary care service.

4.6 Further, a conscientious objector may not have certain knowledge of the views of another practitioner to whom a referral is made. This may aggravate delays.

4.7 The AMA (WA) believes that there should be a requirement to provide information and advice in order to ensure the patient can access abortion services, as opposed to requiring a medical referral. A conscientious objector should provide access points where a patient may access information on how to secure an abortion service. This could be a centrally administrated State service that lists abortion service providers across the State.

5 Regulatory options in relation to gestational limit for additional requirements

5.1 Importantly, determining the gestational limit for late abortions is a clinical consideration and the AMA (WA) believes that the WA Government should follow medical advice when identifying a gestational limit for additional requirements. The expert view of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists is critical to informing where the appropriate gestational limit for additional requirements should sit. It may be necessary to consider whether some additional requirements would apply prior to a newly determined gestational limit for late abortions.

5.2 Late term surgical abortion is a procedure with potential for significant complications such as uterine rupture, hysterectomy, sepsis and maternal death.

5.3 The AMA (WA) believes that 22 weeks gestation would be more appropriate when determining a gestational limit for additional requirements.

5.4 Increasing the gestational limit to 22 weeks provides additional time post 18-20-week anatomy scan for patients and their care providers to consider the indications and reasons for accessing abortion services.

5.5 Maternal-fetal subspecialists will be required in the majority of late term abortions. There are a small number of maternal-fetal subspecialists in WA and limited infrastructure to carry out abortions beyond 22 weeks gestation.

5.6 Abortions after 22 weeks can be extremely distressing for patients and for clinicians involved. There may be limited maternal-fetal medicine subspecialists and midwifery staff prepared to carry out abortions beyond 22 weeks gestation. Infants become viable in the 22+0 to 24 weeks gestational period, raising the prospect of requiring an ultrasound guided injection of a lethal substance into the bloodstream of the fetus (a specialist technical skill) or risking birth of a live born baby that may cry and move, potentially distressing parents and attending staff. These matters require additional expert counselling by specialists with relevant expertise.

6 Regulatory options in relation to a Ministerial Panel

6.1 Approving late term abortions should require expert specialist medical consideration and approval.

6.2 The AMA (WA) believes that if the current requirement of a Ministerial Panel to approve late term abortions is removed, legislative reform should ensure that an additional two specialist registered medical practitioners, with appropriate qualifications and experience are required. At least one should be an Obstetrician and Gynaecologist, and the second should have specialist medical registration and clinical expertise relevant to the patient's needs, for example maternal-fetal medicine, rural and remote medicine, paediatric neurology, paediatric cardiology or psychiatry.

6.3 The AMA (WA) notes that the terms 'additional medical practitioner' and 'consulted' referred to in the Discussion Paper, are not specific enough to guarantee the required expertise needed in this small number of abortions where expert advice and counselling is required to ensure:

- 6.3.1 patient safety;
- 6.3.2 that relevant investigations can be arranged and conducted; and
- 6.3.3 that patient care outcomes are optimised.

6.4 A medical practitioner is a person who is registered under the *Health Practitioner Regulation National Law (WA) Act 2010*. Many would not have adequate knowledge and/or experience of obstetrics, maternal-fetal health medicine or women's health, to appropriately provide and support informed decision making relating to late term abortion.

6.5 The term 'consultation' used in the Discussion Paper denotes communication and feedback consideration, it does not require implementation of the expert clinical view. The AMA (WA) disagrees with a 'consultation' standard being applied to late term abortion decisions.

6.6 Many late term abortions are performed because of complex fetal anomalies, severe mental health concerns or severe medical conditions affecting the mother (eg. leukaemia or deteriorating cardiac disease). Failure to understand the complex medical circumstances and prepare appropriately may lead to direct patient harm.

7 Regulatory options in relation to health service approval to perform late abortions

7.1 Not all hospitals are equipped to carry out late term abortions.

7.2 Hospitals should be credentialed to provide services, such as late term abortions. Those that are appropriately credentialed and staffed should be able to perform late abortions. Beyond this, additional Ministerial approval should not be required.

7.3 Reducing barriers to access abortion services should not come at the expense of patient safety.